COUNSELOR IN TRAINING PROGRAM AT ALBEMARLE ACRES

IDENTIFICATION/EMERGENCY INFORMATION

Child's Name_____ School_____D.O.B_____

Address_____ City_____ Zip_____

Mother/Guardian_____ Phone_____

Employment_____Hours_____ Phone_____

Father/Guardian_____ Phone_____

Employment_____Hours_____ Phone_____

Physician_____ Phone_____

Medical Insurance_____ Policy #_____

If parents can't be reached, call

Name_____ Phone_____ Relation_____

Name_____ Phone_____ Relation_____

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IDENTIFYING INFORMATION

Eye Color_____ Hair Color_____ Gender_____

Height_____ Weight_____ Identifying Marks_____

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HEALTH INFORMATION

Any serious illness or hospitalization_____

Medications currently taking_____

Please list any limitations, health concerns, etc_____

Allergies(asthma, medication, etc)_____

Reactions to above_____

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PERSONS OTHER THAN PARENT/GUARDIAN AUTHORIZED TO PICK UP CHILD

Name_____ Phone_____ Relation_____

Name_____ Phone_____ Relation_____

Name_____ Phone_____ Relation_____

Parent/Guardian Signature_____Date_____